KAMALA D. HARRIS
Attorney General of California
LINDA K. SCHNEIDER
Supervising Deputy Attorney General
RITA M. LANE
Deputy Attorney General
State Bar No. 171352
110 West "A" Street, Suite 1100
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 645-2614
Facsimile: (619) 645-2061
Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **RICHARD LAWRENCE STAUTER** **4723 Jade Court** **Lancaster, CA 93536** **Registered Nurse License No. 688072** Respondent.	Case No. 2012-411 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about September 5, 2006, the Board of Registered Nursing issued Registered Nurse License Number 688072 to Richard Lawrence Stauter (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2012, unless renewed.

///

///

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2750 of the Code provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time.

STATUTORY PROVISIONS

6. Section 2761 of the Code states:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> . . .

7. Section 2762 of the Code states:

> In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:
>
> (a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.
>
> (b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.
>
> . . . .

///

(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

8. Section 4060 of the Code states, in pertinent part, that no person shall possess any controlled substance without a prescription by a physician.

9. Section 11173 (a) of the Health and Safety Code provides, in pertinent part, that (a) no person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge.

COSTS

10. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUGS

11. Pyxis is a trade name for an automated single-unit dose medication dispensing system that delivers medications, typically narcotics and controlled substances, to an individual authorized to access the system by using a password known only to that individual. Once the password is entered, the medication drawer or container is unlocked and the medication is removed from the machine for administration to the designated patient. The medication transaction is recorded and stored in a data system, containing information about the identity of who accessed the system, the name of the patient who is supposed to receive the medication, the time the system was accessed, the type of medication removed and the quantity of medication that was removed. Sometimes only portions of the withdrawn narcotics are given to the patient. The portions not given to the patient are referred to as wastage. This wastage must be witnessed by another authorized user and is also recorded by the Pyxis machine.

///

12. Demerol, a brand name for meperidine, is a Schedule II controlled substance as designated by Health and Safety Code Section 11055(c)(17) and is a dangerous drug pursuant to Business and Professions Code section 4022. Demerol is used to treat pain.

13. Dextromethorphan is the active ingredient in Delsym, an over-the-counter cough medicine. Dextromethorphan is an antitussive drug and has also found other uses in medicine, ranging from pain relief to psychological applications. When exceeding label-specified maximum dosages, dextromethorphan acts as a dissociative hallucinogen.

14. Dilaudid, a brand name for hydromorphone, is a Schedule II controlled substance as designated by Health and Safety Code Section 11055(b)(1)(j) and is a dangerous drug pursuant to Business and Professions Code section 4022. Dilaudid is used to treat moderate to severe pain.

15. Morphine/Morphine Sulfate is a Schedule II controlled substance as designated by Health and Safety Code section 11055(b)(1)(L), and is a dangerous drug pursuant to Business and Professions Code section 4022. Morphine is used to treat severe pain.

16. Oxycontin/oxycodone is a Schedule II controlled substance as designated by Health and Safety Code Section 11055(b) and is a dangerous drug pursuant to Business and Professions Code section 4022. Oxycontin/oxycodone is used to treat moderate to severe pain.

17. Vicodin, a brand name for hydrocodone and acetaminophen, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055(b)(1)(i) and a dangerous drug pursuant to Business and Professions Code section 4022. Vicodin is used to treat severe pain.

FACTUAL ALLEGATIONS

18. Respondent was employed as a registered nurse at Antelope Valley Hospital (AVH) from 2006 to June 2010.

19. In an interview on April 21, 2011, Respondent admitted to a Department of Consumer Affairs' investigator, that while he worked as a registered nurse at AVH, he used controlled substances such as Dilaudid, Morphine and Vicodin on a regular basis that he took from the hospital supplies from the beginning of 2007 to August 2007.

///

20. Respondent admitted that in August 2007, Respondent voluntarily entered a drug diversion program to address his drug addiction. In May 2010, Respondent began using alcohol and controlled substances on a daily basis. Respondent admitted he was diverting controlled substances from AVH for his personal use until he got fired in June 2010.

21. In June 2010, Respondent began working for the nursing registry of Medical Staffing Network, and was assigned to work at St. Mary Medical Center (St. Mary's) from July 12, 2010 to October 30, 2010.

22. From May 2010 through November 2010, Respondent obtained controlled substances from AVH and St. Mary's, by pulling the medication from the Pyxis under false pretenses. Respondent would pull the medication under patients' names not assigned to him, or for patients who did not have physician's orders, and then pretend to waste the medication. Respondent would not waste the medication, but instead, self administered the drugs intravenously during breaks and lunches while working at St. Mary's. Respondent admitted to investigators that he used controlled substances that he took from the hospitals on a daily basis while working at both AVH and St. Mary's.

23. Respondent admitted to investigators that he stole a prescription pad from St. Mary's and forged prescriptions for himself in order to obtain Oxycontin for his personal use during the months of October and November 2010.

24. In November 2010, Respondent was hired as a registered nurse by Tehachapi State Prison (Tehachapi). While working at Tehachapi, Respondent began going through narcotics withdrawal and was hospitalized from November 11, 2010 to November 15, 2010. Respondent took a leave of absence from Tehachapi and entered an in-house diversion program on November 18, 2010.

25. On November 28, 2010, while Respondent was going through his in-house diversion program, Respondent self-reported to diversion staff that he used morphine daily for the past four years; used oxycontin/oxycodone daily for the past year and used dextromethorphan weekly for the past three years.

///

26. Pyxis Reports from AVH for the time period of March 2010 through April 7, 2010, and patient medical records revealed that drugs withdrawn by Respondent from the Pyxis, were not charted as administered or wasted, were not given to the patients, were consistently wasted or were given to patients who did not have physician's orders for the medication. Regardless, Respondent failed to account for medication in his possession. A review of Respondent's Pyxis drug activity at AVH revealed the following:

27. Patient 1: On March 12, 2010, patient 1 had a physician's order for Dilaudid 2 mg for pain.

a. On March 12, 2010, at 0906 hours, Respondent withdrew 2 mg Dilaudid from Pyxis for patient 1. Respondent charted that 2 mg of Dilaudid were given to patient 1, but failed to chart the time the medication was administered. Additionally, nursing notes indicate that the patient did not have any indications of pain.

28. Patient 2: On March 17, 2010, patient 2 did not have a physician's order for Morphine.

a. On March 17, 2010, at 0701 hours, Respondent withdrew 10 mg Morphine from Pyxis for patient 2 without doctor's orders. 30 minutes later, Respondent wasted the 10 mg of Morphine.

29. Patient 3: On March 21, 2010, patient 3 had a physician's order for Dilaudid 1 mg for pain.

a. On March 21, 2010, at 0625 hours, Respondent withdrew 2 mg Dilaudid from Pyxis for patient 3. Respondent charted that 1 mg of Dilaudid was given to patient 3. Respondent failed to chart the wastage of 1 mg of Dilaudid on the Medication Administration Record (MAR) or in the nursing notes. Respondent failed to account for 1 mg of Dilaudid.

30. Patient 4: On March 24, 2010, patient 4 did not have a physician's order for Dilaudid 2 mg.

///

///

///

a. On March 24, 2010, at 1528 hours, Respondent withdrew 2 mg Dilaudid from Pyxis for patient 4 without doctor's orders. Respondent charted that 1 mg of Dilaudid was given to patient 4 and that 1 mg of Dilaudid was wasted.

b. On March 24, 2010, at 1550 hours, Respondent withdrew 2 mg Dilaudid from Pyxis for patient 4 without doctor's orders. Respondent charted that 0 Dilaudid was given to patient 4 and that 1 mg of Dilaudid was wasted. Respondent failed to account for 1 mg of Dilaudid.

31. Patient 5: On March 24, 2010, patient 5 had a physician's order for Dilaudid 2 mg for pain.

a. On March 24, 2010, at 1727 hours, Respondent withdrew 2 mg Dilaudid from Pyxis for patient 5. Respondent charted that 2 mg of Dilaudid were given to patient 5 at 1720 hours. Additionally, notes indicate that the doctor re-assessed the patient at 1700 hours for pain and patient 5 was pain free at that time.

32. Patient 6: On March 25, 2010, records indicate that patient 6 had a physician's order for Dilaudid 1 mg for pain. However, the doctor who allegedly wrote the physician's order for the Dilaudid 1 mg stated that he did not write this order for patient 6.

a. On March 25, 2010, at 0732 hours, Respondent withdrew 4 mg Dilaudid from Pyxis for patient 6. Respondent charted that 1 mg of Dilaudid was given to patient 6 and that 3 mg of Dilaudid was wasted. Per Respondent's MAR entry, patient 6 received 1 mg of Dilaudid that he was not prescribed to receive.

33. Patient 7: On March 28, 2010, patient 7 had a physician's order for Dilaudid 2 mg, but did not have a physician's order for Dilaudid 4 mg.

a. On March 28, 2010, at 1328 hours, Respondent withdrew 4 mg Dilaudid from Pyxis for patient 7 without doctor's orders. Respondent charted that 4 mg of Dilaudid was given to patient 7. Per Respondent's MARentry, patient 7 received 2 mg of Dilaudid in excess of what he was prescribed to receive.

34. Patient 8: On March 28, 2010, patient 8 had a physician's order for Morphine 8 mg for pain.

///

a. On March 28, 2010, at 1305 hours, Respondent withdrew 10 mg of Morphine from Pyxis for patient 8. Respondent charted that 8 mg of Morphine were give to patient 8 at the time that patient 8 had already been discharged from the hospital. Respondent also charted that 2 mg of Morphine were wasted. Respondent failed to account for 8 mg of Morphine.

35. Patient 9: On March 28, 2010, patient 9 did not have a physician's order for Dilaudid 2 mg.

a. On March 28, 2010, at 1737 hours, Respondent withdrew 2 mg Dilaudid from Pyxis for patient 9 without doctor's orders. Respondent charted that 2 mg of Dilaudid were given to patient 9.

36. Patient 10: On April 1, 2010, patient 10 had a physician's order for Morphine 4 mg for pain.

a. On April 1, 2010, at 0943 hours, Respondent withdrew 4 mg of Morphine from Pyxis for patient 10. Respondent charted that 4 mg of Morphine were give to patient 10 at the time that patient 10 had already been discharged from the hospital. Respondent failed to account for 4 mg of Morphine.

37. Patient 11: On April 2, 2010, patient 11 had a physician's order for Dilaudid 2 mg for pain.

a. On April 2, 2010, at 1629 hours, Respondent withdrew 4 mg of Dilaudid from Pyxis for patient 11. Respondent charted that 3 mg of Dilaudid were given to patient 11 and that 1 mg of Dilaudid was wasted. Per Respondent's MAR entry, patient 11 received 1 mg of Dilaudid in excess of what he was prescribed to receive.

b. On April 2, 2010, at 1721 hours, Respondent withdrew 4 mg of Dilaudid from Pyxis for patient 11. Respondent charted that 3 mg of Dilaudid were given to patient 11 and that 1 mg of Dilaudid was wasted. Per Respondent's MAR entry, patient 11 received 1 mg of Dilaudid in excess of what he was prescribed to receive. Additionally, patient 11 had received 3 mg of Dilaudid for pain only one hour earlier at 1629 hours.

///

///

38. Patient 12: On April 4, 2010, patient 12 had a physician's order for Dilaudid 2 mg for pain. Patient 12 was not assigned to Respondent.

a. On April 4, 2010, at 0920 hours, Respondent withdrew 2 mg of Dilaudid from Pyxis for patient 12. Respondent failed to chart the administration or wastage of this medication on the MAR or in the nursing notes. Respondent failed to account for 2 mg of Dilaudid.

39. Patient 13: On April 4, 2010, patient 13 had a physician's order for Dilaudid 2 mg, but the physician's order appears to have been changed to Dilaudid 4 mg.

a. On April 4, 2010, at 1057 hours, Respondent withdrew 4 mg Dilaudid from Pyxis for patient 13. Respondent charted that 2 mg of Dilaudid were given to patient 13 at 1100 hours. Respondent failed to account for 2 mg of Dilaudid.

b. On April 4, 2010, at 1207 hours, Respondent withdrew 2 mg Dilaudid from Pyxis for patient 13. Respondent charted that 2 mg of Dilaudid were given to patient 13 at 1145 hours, more than 20 minutes before it was withdrawn.

c. On April 4, 2010, at 1223 hours, Respondent withdrew 2 mg Dilaudid from Pyxis for patient 13. Respondent charted that 4 mg of Dilaudid were given to patient 13 at 1230 hours, less than one hour after the previous dose was administered by Respondent per his MAR entries.

d. On April 4, 2010, at 1242 hours, Respondent withdrew 4 mg Dilaudid from Pyxis for patient 13. Respondent failed to chart the administration or wastage of this medication on the MAR or in the nursing notes. Respondent failed to account for 4 mg of Dilaudid. Additionally, Patient 13 was given 12 mg of Dilaudid in a 2 hour time period and was discharged 30 minutes after the last 4 mg dose was administered, per Respondent's MAR entries for this patient.

40. Patient 14: On April 4, 2010, patient 14 had a physician's order for Dilaudid 1 mg for pain.

a. On April 4, 2010, at 1707 hours, nurse SL withdrew 2 mg Dilaudid from Pyxis for patient 14. Nurse SL charted that 1 mg of Dilaudid was given to patient 14 and 1 mg of Dilaudid was wasted.

///

///

b. On April 4, 2010, at 1727 hours, only 20 minutes after the dose was withdrawn by nurse SL, Respondent withdrew another 2 mg Dilaudid from Pyxis for patient 14. Respondent charted that 1 mg of Dilaudid was given to patient 14 and 1 mg of Dilaudid was wasted.

c. On April 4, 2010, at 1759 hours, Respondent withdrew 2 mg Dilaudid from Pyxis for patient 14. Respondent failed to chart the administration or wastage of this medication on the MAR or in the nursing notes. Respondent failed to account for 2 mg of Dilaudid.

d. On April 4, 2010, at 1809 hours, Respondent withdrew 2 mg Dilaudid from Pyxis for patient 14. Respondent charted that he wasted 2 mg of Dilaudid.

41. Patient 15: On April 7, 2010, patient 15 had a physician's order for Dilaudid 1 mg for pain.

a. On April 7, 2010, at 0652 hours, Respondent withdrew 2 mg of Dilaudid from Pyxis for patient 15. Respondent charted that 2 mg of Dilaudid were given to patient 15. Per Respondent's MAR entry, patient 15 received 1 mg of Dilaudid in excess of what he was prescribed to receive.

b. On April 7, 2010, at 1050 hours, Respondent withdrew 4 mg of Dilaudid from Pyxis for patient 15. Respondent charted that 4 mg of Dilaudid were given to patient 15. Per Respondent's MAR entry, patient 15 received 1 mg of Dilaudid in excess of what he was prescribed to receive.

42. Pyxis Reports from St. Mary's for the time period of September 2010 through November 2010, and patient medical records revealed that drugs withdrawn by Respondent from the Pyxis, were not charted as administered or wasted, were not given to the patients, were consistently wasted or were given to patients who did not have physician's orders for the medication. Regardless, Respondent failed to account for medication in his possession. A review of Respondent's Pyxis drug activity at St. Mary's revealed the following:

43. Patient A: On October 3, 2010, patient A did not have a physician's order for Demerol.

///

///

a. On October 3, 2010, at 0221 hours, Respondent withdrew 50 mg of Demerol from Pyxis for patient A, even though patient A did not have a physician's order for Demerol. Respondent failed to chart the administration of this medication on the MAR or in the nursing notes. Respondent failed to account for 50 mg of Demerol.

44. Patient B: On September 22, 2010, patient B did not have a physician's order for Dilaudid.

a. On September 22, 2010, at 1911 hours, Respondent withdrew 1 mg of Dilaudid from Pyxis for patient B, even though patient B did not have a physician's order for Dilaudid. Respondent failed to chart the administration or wastage of this medication on the MAR or in the nursing notes. Respondent failed to account for 1 mg of Dilaudid.

45. Patient C: On October 18, 2010, patient C did not have a physician's order for Dilaudid.

a. On October 18, 2010, at 0407 hours, Respondent withdrew 1 mg of Dilaudid from Pyxis for patient C, even though patient C did not have a physician's order for Dilaudid. Respondent failed to chart the administration or wastage of this medication on the MAR or in the nursing notes. Respondent failed to account for 1 mg of Dilaudid.

46. Patient D: On September 24, 2010, patient D did not have a physician's order for Dilaudid.

a. On September 24, 2010, at 0051 hours, Respondent withdrew 2 mg of Dilaudid from Pyxis for patient D, even though patient D did not have a physician's order for Dilaudid. Respondent did not chart the administration of this medication in the MAR or nursing notes. At 0151, Respondent wasted 2 mg of Dilaudid.

47. Patient E: On October 24, 2010, patient E did not have a physician's order for Morphine.

a. On October 24, 2010, at 2253 hours, Respondent withdrew 10 mg of Morphine from Pyxis for patient E, even though patient E did not have a physician's order for Morphine.

///

///

Respondent failed to chart the administration or wastage of this medication on the MAR or in the nursing notes. Respondent failed to account for 10 mg of Morphine.

48. Patient F: On September 23, 2010, patient F did not have a physician's order for Dilaudid.

a. On September 23, 2010, at 0243 hours, Respondent withdrew 2 mg of Dilaudid from Pyxis for patient F, even though patient F did not have a physician's order for Dilaudid. Respondent failed to chart the administration of this medication on the MAR or in the nursing notes. At 0244, Respondent wasted 2 mg of Dilaudid.

49. Patient G: On October 24, 2010, patient G had a physician's order for Demerol.

a. On October 24, 2010, at 2046 hours, Respondent withdrew 50 mg of Demerol from Pyxis for patient G, then cancelled the order. A discrepancy was noted in the inventory of Demerol that day, and according to Pyxis there should have been more Demerol in the inventory. Respondent failed to account for 50 mg of Demerol.

50. Patient H: On October 23, 2010, patient H had a physician's order for 0.5 mg Dilaudid.

a. On October 23, 2010, at 0326 hours, Respondent withdrew 1 mg of Dilaudid from Pyxis for patient H. Respondent charted the administration of 0.5 mg of Dilaudid on the MAR, but failed to record any wastage. Respondent failed to account for 0.5 mg of Dilaudid.

51. Patient I: On October 31, 2010, patient I had a physician's order for 1 mg Dilaudid.

a. On October 31, 2010, at 0347 hours, Respondent withdrew 1 mg of Demerol from Pyxis for patient I, then cancelled the order at 0503. A discrepancy was noted in the inventory of Dilaudid that day. The subsequent count was noted to be 39 mg of Dilaudid, when per Pyxis, it should have been 40. Respondent failed to account for 1 mg of Demerol.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct - False, Incorrect or Inconsistent Entries in Hospital/Patient Records)

52. Respondent is subject to disciplinary action for unprofessional conduct under Code section 2762(e) in that he falsified, or made grossly incorrect, or grossly inconsistent entries in

///

hospital and patient records pertaining to controlled substances, when he withdrew medication but failed to chart the wastage or administration of the medication to patients, and withdrew medication that was consistently wasted or were given to patients who did not have doctor's orders for the medication. The facts and circumstances are more specifically set forth in paragraphs 18 through 51 above, and are incorporated herein as though fully referenced.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Obtain or Possess Controlled Substances)

53. Respondent is subject to disciplinary action pursuant to Code section 2762(a), on the grounds of unprofessional conduct, in that Respondent obtained and possessed controlled substances in violation of Code section 4060 and Health and Safety Code section 11173(a) when he unlawfully withdrew and possessed controlled substances from the Pyxis machines at AVH and St. Mary's for his own personal use and used a stolen prescription pad to write prescriptions for the controlled substance Oxycontin. The facts and circumstances are more specifically set forth in paragraphs 18 through 51 above, and are incorporated herein as though fully referenced.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Use of Controlled Substances)

54. Respondent is subject to disciplinary action pursuant to Code section 2762(b) in that he engaged in unprofessional conduct when he used controlled substances in a manner dangerous or injurious to himself and others when he worked as a registered nurse after using controlled substances from 2006 through 2010. The facts and circumstances are more specifically set forth in paragraphs 18 through 51 above, and are incorporated herein as though fully referenced.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 688072 issued to Richard Lawrence Stauter;

///

///

2. Ordering Richard Lawrence Stauter to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and

3. Taking such other and further action as deemed necessary and proper.

DATED: December 30, 2011

for LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

SD2011801393
80577622.doc